☑ Checklist for Assessing Your Organization's Readiness for Reducing Seclusion and Restraint

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Introduction

There is a growing consensus in the field of behavioral/mental health care that the use of restrictive interventions, i.e. seclusion and physical and mechanical restraint can be harmful and therefore should be minimized. The purpose of this checklist is to provide behavioral healthcare organizations with a systematic approach for identifying factors that influence the reduction of seclusion and restraint and for assessing the level of progress the organization is making toward implementing/addressing each of these factors.

This document is divided into two parts. The first provides background information to assist in completing the checklist and using the results. The second part contains the checklist, which is composed of nine sections. Although instructions are included on the first page of the checklist, users are encouraged to read the following information.

Methodology

This checklist is based on a review of more than eighty publications and Internet resources (References). Content analysis was used to identify reoccurring themes and the elements that comprise those themes. For example, *leadership* may involve creating a vision for the organization that reflects its philosophy of treatment, ensuring that there is a structure to support decision-making, setting expectations and goals, and promulgating procedures regulating the implementation of restrictive interventions.

The checklist is divided into nine sections (see Reoccurring Themes, next page). These themes have been recognized in a number of other studies (Appendix, Table 1) which lend credibility as well as face, content and construct validity to the instrument. Where appropriate, the items progress in a 'natural' order. For example, under Leadership, it would be expected that the CEO demonstrate commitment to reducing seclusion and restraint (item 1-A) prior to the development of a strategic plan (item 1-D). Nonetheless, not all items can or do flow sequentially as implementation of activities to reduce seclusion and restraint do not always occur linearly and may in fact be part of a continuous and/or cyclic process.

The rating scale has been adapted from the *Transtheoretical Model of Change* (Prochaska and DiClemente, 1984 and described in Miller, 1999), which suggests a continuum through which people progress as they attempt to change individual behaviors. This sequence of progression can be adapted to organizations as its membership contemplates, initiates, and sustains change in order to substantially alter the organization's existing level of performance.

A Delphi technique (via email) was used to pretest the instrument and involved two rounds of review and modification. The first draft of the instrument was sent to seven reviewers for examination and comment. To address content and construct validity, reviewers consisted of clinicians, program managers, and educators in the field of behavioral health care from across the United States and Canada who were familiar with issues related to use of seclusion and restraint. Based on reviewer feedback, the instrument was revised and then resubmitted for another round of review. During this process, interest in the instrument was expressed by a number of other individuals therefore thirteen additional reviewers were added for the second round. The second round included clinicians, program managers, and representatives from national organizations that were involved in seclusion and restraint reduction projects.

Based on feedback from the second round of reviews, a third draft of the instrument was subsequently field tested by five behavioral health care facilities in the U.S.: four state hospitals and one residential treatment program. Three of the state hospitals serve adult patients, while one state hospital and the residential program serve child and adolescent populations. Finally, the checklist was reviewed by graduate students at a state university who were completing a course in instrument construction.

Revisions have been made in response to feedback received during each phase of the pretesting process. For example, items have been reworded for clarity, items were deleted as not representative of the process, items were added, and the response scale was reworded. Feedback was also provided in regard to this narrative section, particularly in regard to issues related to administration and use of the instrument, which have been substantially revised. Although the original research focused on the use of restrictive interventions with children and adolescents, the term 'client' is now used to broaden application of the checklist based on age and setting. The checklist is appropriate to a variety of populations as well as to a continuum of treatment settings including hospitals, residential facilities, and outpatient treatment centers.

Reoccurring Themes

There are a number of themes and factors which reoccur in the literature. For example, the Child Welfare League of America (Bullard, Fulmore, and Johnson, 2003) and the National Technical Assistance Center (2003) have identified six components for reducing the use of seclusion and restraint. Delany (2002) identified four major themes and a number of secondary factors, and the study on which this checklist is based identified nine key themes. Although these studies may have used different terminology, they essentially address the same overlapping themes (Appendix, Table 1). Additionally, all of these themes are incorporated in Joint Commission (JCAHO) compliance guidelines for the use of restraint and seclusion (2002).

From the perspective of organizational development, these themes and factors are interactive. For example, the educational curriculum should orient staff to the structure of the treatment program(s) and provide staff with the knowledge and skills to implement programs consistently across shifts. Therefore, progress addressing one factor may influence progress in achieving another.

Although no theme is paramount, a number of studies suggest that without effective leadership, efforts to reduce the use of seclusion and restraint will be unfocused, unsupported, and ultimately less effective. For example, the New York Commission on Quality Care (1994) concluded that "rather than facility demographic or patient clinical characteristics, it is the treatment preferences and practices of administrators and clinical staff which are the predictors of low rates of seclusion and restraint. The Commission found such facilities have administrators who believe strongly in minimal use of restraint and seclusion and have instituted practices and promoted efforts to keep usage low." (p. 3)

Finally, the checklist attempts to operationalize these themes by identifying specific actions/ factors that should occur in order to reduce use of seclusion and restraint. Although this list is comprehensive, it should not be considered exhaustive, as additional actions, unique to a particular organization are likely to be identified through the process of comparing existing performance to the checklist.

1. Leadership: Action to reduce the use of seclusion and restraint is the result of a conscious decision on the part of both administrative and clinical leaders that it is worthy goal for which the organization is willing to commit its resources and without that commitment, efforts to reduce the use of restrictive interventions will be unfocused and less effective.

2. Orientation and Training: A number of organizations that were successful in reducing seclusion and restraint implemented a comprehensive training curriculum that was delivered in a consistent manner. Training and new employee orientation should introduce staff to the agency's treatment philosophy, organizational culture, program structure, and policies and procedures relevant to the use of restrictive interventions and provide staff with the competencies needed for effective client support and management, and healthy relationships. (Appendix – 2)

3. Staffing: Staffing ensures that adequate numbers of qualified employees are available to implement the organization's mission. In some of the studies, organizations were able to influence the use of seclusion and restraint by ensuring that adequate numbers of employees were available at critical times, such as during transitions, at change of shift, and in the evening.

4. Environmental Factors: Physical environment relates to actual physical factors, such as square footage, ventilation, temperature, lighting, noise, and odors, as well as the way that staff and clients experience the environment. Although the literature suggests that addressing issues related to the physical environment may make the setting safer, there is not as yet empirical evidence to demonstrate a causal link between environment factors and an actual reduction in the use of seclusion and restraint.

5. Programmatic Structure: A program is a purposeful set of activities which are carried out within a specified context in order to achieve desired outcomes. Programs consist of routines, rituals, and rules which in a behavioral health setting focus on creating a supportive and therapeutic milieu. Programs that have been successful in reducing the use of seclusion and restraint are typically based on empowering clients – this is often referred to as *strengths-based* treatment – to take responsibility for their behaviors (in the context of client's physical, cognitive, affective, and social development and disabilities), rather than imposing external control through the unit program and staff interactions. This may involve normalizing routines and allowing freedoms that are not historically typical of institutional care. (Appendix, Table 3)

6. Timely and Responsive Treatment Planning: Treatment planning is individualized, involves the client and other stakeholders, and is responsive to changes in the client's behavior and progress in treatment. Every effort is made to engage the individual (and family), so that he/she does not perceive it as just a process where others do something to/for the client. Significant changes in client behavior are promptly responded to through review and as needed, revision, of the treatment plan. For example, one study found that internal clinical consultation helped identify alternative treatment approaches which were not immediately evident to the client's primary caregivers. (Donat, 1998)

7. Processing after the Event (debriefing): Debriefing with the client helps the client reconnect with staff, peers, and the milieu. It also provides an opportunity to reflect on the behaviors that lead to the intervention and to identify coping strategies and behaviors that can be used in the future. Debriefing with the client takes into consideration the individual's maturation and ability to make use of the process. There is also a need to process the event with staff particularly around their feelings, reactions, and safety, as well as examining the situation to determine what worked

or didn't work and different approaches that might be tried in the future. Issues related to countertransference should be addressed. Consequently, the process for conducting a debriefing is a component of the training curriculum.

8. Communication and Consumer Involvement: The President's New Freedom Commission on Mental Health emphasizes the need for greater inclusion of consumers and their families in the treatment process, with specific emphasis on self-determination. This section highlights factors that enhance communication and involvement of consumers, for example, staff interact with the client to ensure they not isolated during the intervention and staff are responsive of the client's need to interact and reintegrate back into the milieu after the intervention. Family and stakeholders are informed of the organization' policies and are informed when these interventions are used, including an explanation of why the intervention was necessary. In an open organization, clients, families and other stakeholders are included in change processes, such as developing programs, policies, and procedures.

9. Systems evaluation and quality improvement: The organization establishes policies, procedures, and systems for continuous evaluation of the need for and appropriate use of restrictive interventions. This involves more than reviewing utilization data. Data is analyzed and used to evaluate the effectiveness of system wide efforts to achieve the organization's goals regarding the reduction and use of restrictive interventions.

Scoring Guidelines

The Transtheoretical Model of Change was originally developed as way of conceptualizing the "sequence of stages through which people typically progress as they think about, initiate, and maintain new behaviors" (Miller, 1999, p. 16), particularly when applied to the field of substance abuse treatment. The model assumes change is not linear and that individuals may move back and forth between stages.

The model also serves as means of identifying appropriate interventions based on the individual's stage of change. For example, a client who appears to be in the *contemplative stage* might be ambivalent about the problem but would probably accept information about the adverse affects of substance use. A client in the *action stage* would probably benefit from process oriented therapies and support groups.

For this checklist, the model was adapted and based on peer reviewer feedback, the descriptors changed to: *No Action, Espoused, Intermittent Action*, *Action*, and *Sustained Action*. A choice is also provided if there is insufficient information or additional information is needed to make an assessment. When this model is applied to organizations, change is also perceived as a longitudinal process occurring in stages, which depending on circumstances may not proceed in a linear fashion. And because reduction of seclusion and restraint is a complex process, organizations may find themselves moving forward with certain activities but not moving as quickly in other areas. For this reason, each theme should be assessed independently of other themes and it may be possible that, although interrelated, elements may be progressing independently as well. For example, an administrator may have clearly articulated that reduction of seclusion and restraint is a primary goal for the organization, but he/she may not have taken the additional steps to affect that change.

To assist in scoring, the following information is provided about each stage with examples of how it might be assessed at the *organizational level*:

0 = Insufficient Information: Individuals completing the checklist may not have the information, data, or knowledge on which to base an informed decision. Checking this box indicates the need to obtain the needed information and to return to and score the item once that information has been acquired.

1 = No Action / No Discussion: During this stage there is no formal consensus within the organization that a problem exists and if some members think there may be a problem there is no concerted effort or intention to address the problem. For example, despite data indicating high usage of seclusion and/or restraint, organizational members may articulate that this "just comes with the territory" and should be expected as an aspect of providing behavioral healthcare services. In such an organization, review of data is perfunctory and there is no formalized process for making use of the data, such as establishing goals or developing a strategic plan.

2 = Espoused: At this stage, there is growing recognition of a problem at the individual member level, but still no consensus in regard to the depth or breadth of the problem and what might be done about it. There may be greater discussion of the problem in committee meetings and a desire to obtain information on which to evaluate the extensiveness of the problem. However, there is still a tendency to accept seclusion and restraint as a necessary evil and some members may argue for the therapeutic benefits of these actions. The lack of consensus may result in continued vacillation, even when there is growing evidence that failure to act may be compromising the quality of care. Management may espouse the need to reduce the use of seclusion and restraint, but takes no immediate action. Although preliminary planning may occur, no action steps are taken to implement the plan.

3 = Intermittent / Inconsistent Action: At this stage, some actions are taken although they may not be focused to a particular goal. For example, there may still not be consensus within the organization regarding the scope and magnitude of the problem or the need for a systematic approach to address the problem. Therefore, the organization may or may not have developed a strategic plan for seclusion and restraint reduction. When goals and plans are not formulated, actions that are taken may be fragmented and may or may not contribute to long-term gains. For example, a program manager in one area may originate training for employees under his/her supervision, but it is not delivered consistently due to resource problems and it is not made available to caregiver staff throughout the organization. Policies and procedures may be revised and disseminated to staff, but mechanisms are not put into place to ensure that they are supported and carried out effectively. This may lead to frustration and a perception by caregiver staff that management is failing to lead.

4 = Action: To achieve this stage, the organization has formally recognized the scope of the problem and there is consensus within the organization to reduce seclusion and restraint use. A structured planning process has occurred and the actions needed to fulfill goals and to implement the plan are set into motion. For example, a structured, organization wide staff training curriculum might be implemented, that is grounded on the organization's treatment philosophy and values and which enhances staff competencies. In theory, these actions should result in tangible changes in organizational culture. These changes may also produce some distress among organizational members, as values, procedures, and routines are in a state of flux.

The distinction between Espoused, Intermittent Action, and the Action stage is critical and can be summarized by the adage "actions speak louder than words." For example, in the Espoused and Intermittent Action stages, organizations may engage in a number of tentative activities, such as forming committees to study the problem. However, the Action stage is marked by clearly observable and measurable activities that are carried out in order to implement the organization's articulated strategy, such as the number of staff passing a competency based assessment of skills, client and family participation in treatment planning meetings, and changes in staff verbal interactions with clients.

5 = Sustained Action / Maintenance: This stage reflects prolonged behavioral change and resources are invested in maintaining this level of progress. For example, if the organization has been able to achieve a measurable decrease in seclusion use, a conscious effort is made to maintain the activities that lead to that reduction. This requires continued vigilance and a long-term commitment to change. Although changes in key personal can influence this process, these actions are so integrated into the organization's structure that they are self-sustaining.

Administration

This checklist is a *tool* for completing an *internal* assessment and the information should be used to identify areas in need of action. Consequently, this instrument is useful for conducting a 'gap analysis', that is, it can help in identifying the difference between current and desired performance. Completing the instrument helps to create the expectation that the organization will take action in response to factors that need improvement and the next section on analysis and use provides more information about that process.

During the pretesting phase, comments were received regarding use of the data derived from the instrument for benchmarking with other organizations. As currently developed there are several factors that limit the use of this checklist for that purpose. First, the process of administering the instrument will likely differ from site-to-site. For example, employees at different levels within the organization may be involved in completing the checklist. This could compromise the reliability of the data across different sites. Second, because the instrument can highlight deficiencies, organizations may be guarded about sharing such information. Third, variability between settings (e.g., inpatient and outpatient, long-term versus short-term acute, etc.) may make it difficult to create a normative data set, at least without considerable work to risk-adjust the data.

Rather than using the checklist to benchmark performance against other organizations, the instrument should be re-administered at scheduled intervals to assess if the organization is making progress in addressing areas in need of improvement. The timing between administrations will depend on the organization and the level of effort put forth to address these factors. To enhance reliability between these periodic assessments, the same raters should complete the checklist.

The checklist consists of items that operationalize the nine themes. At the present time, the checklist is not designed to produce a summative score for each theme (i.e., you do not add up the ratings to produce a score for that theme), although future analysis is planned to examine that possibility. Instead, each item should be evaluated in the context of the progress that the organization has taken so that the rating for that item acts as a catalyst for action.

During the pretesting phase of instrument construction, feedback was used to modify items to ensure that raters could respond based on a shared understanding of the meaning of each item, i.e., to ensure reliability. However, it was also evident that based on an individual's role within the organization – their experience, values, and access to information – differences will emerge regarding how individuals rate each item. This is particularly true when employees from various levels within the organization are provided opportunity to participate in rating items. For example, a unit/ward supervisor may have a distinctly different perspective of the unit's programmatic structure than a high level administrator.

When differences in ratings emerge, it may initially be construed as discord. However, when used as part of a healthy, internal assessment, the process should engender vigorous discussion, analysis, and consensus building. Consequently, the organization may want to select a member of its staff with facilitation skills to work with others as they analyze and discuss their findings. Raters may also want to examine documentation, such as program documents and agency policies to provide support for a particular rating.

There are several ways that this instrument can be administered within an organization:

1. The checklist should be completed by more than one individual to ensure a comprehensive assessment, from multiple perspectives, and to engage staff in the change process.

2. Regardless of organizational role, the individuals selected to complete the checklist should receive a copy of the instrument which they complete *independently*. They should then come together to share and discuss their ratings. As noted in the next section, raters use this information to identify strengths and areas in need of improvement. Based on pretesting, it should take thirty to forty-five minutes for an individual to complete all sections of the checklist. This suggests that raters should set aside sufficient time to complete this task.

3. At a minimum, the *entire* checklist should be completed by the facility administrator and the executive management team. In behavioral health care organizations this typically includes the heads of clinical services, such as psychiatry, psychology, nursing, social work, and program services. This group is ultimately responsible for articulating the organization's vision about the use of seclusion and restraint, ensuring that there is a plan for the reduction of these interventions, and providing the leadership and direction for the change process. The process of completing the checklist may also highlight areas where the executive management team lacks and therefore needs information on which to base its assessment and fulfill its responsibilities.

4. In addition to the executive management team, the facility may want to designate specific individuals to complete the checklist, such as staff members who are currently involved in seclusion and restraint reduction efforts. The same process of administration should be followed, i.e. completing the checklist independently and then meeting to discuss the results. Differences that arise between the executive management team and this group should be examined.

5. *Sections* of the checklist can also be completed by staff at other levels of the organization. For example, members of a treatment team on a specific unit or ward can complete the sections on Programmatic Structure, Treatment Planning, and Debriefing in order to do a unit/ward level assessment. When completed at this level of the organization, human service workers/technicians responsible for implementing these interventions should be involved in the process as well.

6. The checklist can be administered to all members of the organization in the form of a survey and the results tallied. The advantage of this approach is that it provides a wide scale assessment of staff perceptions and it helps to introduce staff to the concepts that will be addressed in a seclusion and restraint reduction effort. The disadvantage lies in the resources needed to administer a large scale survey, including collecting, aggregating, and analyzing a large data set.

Analysis and Use: Cultural Change and Quality Improvement

The process of using the checklist is similar to developing a treatment plan with a client. The checklist serves as a diagnostic instrument and the client in this case is the organization. During the review and discussion phase, users attempt to develop a consensus rating for each item. Differences in scoring should be examined. In some cases, group members may not agree on an exact score, but can agree that the item could be rated either a 2 or a 3, 4 or 5, etc. For example, the group may believe that for a specific item/factor, the organization is moving from intermittent action into an action phase and a single score does not accurately capture that process. At other times, the group may be unable to agree. In that case, additional information may be needed to determine whether or not the factor should be considered an action that has been successfully implemented or a limitation needing improvement.

In situations where differences become polarized, it may be best to defer addressing that element until staff have had time to assimilate the information and to weigh the different positions. Decision makers may choose to address those items which they believe are more easily achieved within the context of the organization and its resources and defer the more challenging items. Nonetheless, those organizations that have experienced the most success in reducing seclusion and restraint use have acknowledged that it has been accomplished by addressing multiple elements comprehensively, as this results in significant cultural change. For example, Millcreek Behavioral Health Services was selected for the Joint Commission's 2003 Ernest A. Codman Award for quality improvement for its restraint reduction efforts: from 1,025 episodes in 1999 to just 4 four episodes in 2003. Millcreek "emphasized the interdisciplinary treatment plan and a team concept for its staff. Other strategies included staff training in proactive de-escalation techniques; specific monitoring of the use of restraint use; hiring nurses as residential unit managers; establishing clear policies and procedures for the use of restraint; and creating a dedicated nurse monitor to oversee the use of each episode of restraint." (JCAHO, 2004, p.2)

In addition to providing a framework for the response alternatives, the *Transtheoretical Model* was designed to provide guidance in regard to the motivational strategies that might be appropriate at each stage of change. For example, in the 'precontemplative' stage, a client is not yet considering change or is unwilling or unable to change. An appropriate response on the part of a clinician would include establishing rapport and building trust. The clinician can then work with the client to examine their patterns of substance usage and explore with the client their perception of the situation (Miller, 1999).

Organizations can use the checklist in a similar fashion to identify the most effective strategies given the perception of progress for each of the themes and elements. For example, if the facility administrator does not see the need for developing a strategic plan (item 1-D; Non Action / No Discussion), then individuals who are leading the change process may want to share information with the administrator about organizations that have been successful in reducing seclusion and

restraint which when addressed as a quality improvement project, was affected through a strategic planning process (e.g., JCAHO, 2001,b).

The head of a treatment team may be having difficulty ensuring that staff are meeting with clients after events (items 7-C to 7-H; Intermittent / Inconsistent Action). An approach to reinforce this activity might be to create a quality improvement team to compare situations when debriefings occurred and when they were not conducted. The data may indicate that debriefing makes a difference in client responsiveness to these intervention and often results in reduced use of seclusion/restraint. The data may also suggest a need to improve the quality of these interventions so that they are carried out consistent with the organizations policies and guidelines.

Cultural Change

The checklist can serve as a catalyst for change because *actions* taken in response to identified gaps may have a profound impact on the organization's culture and operations. Execution of these actions should occur as both a top-down and bottom-up process. From the top, management must provide the vision, goals, leadership, and resources. The change process is not haphazard, rather it is strategic and management is responsible for creating the foundation on which change is established. From the bottom, service providers must take ownership of new processes. For example, psychiatric technicians should be included in decisions about changes in program structure, scheduling, and client treatment plans.

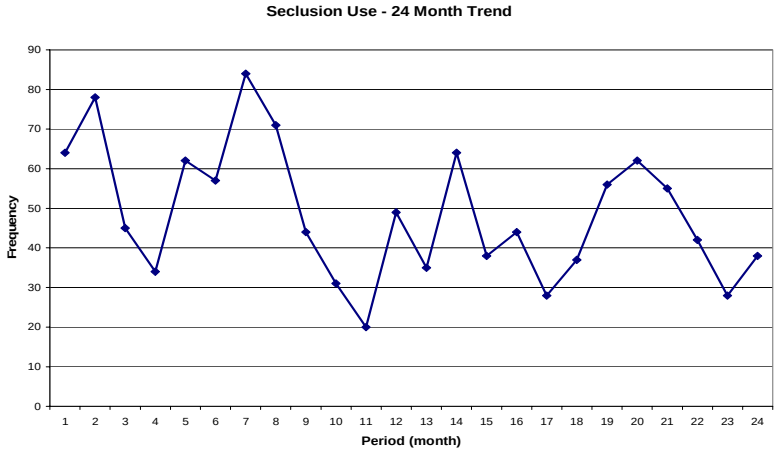
Second, an organization's culture is its internal identity (based on norms, practices, beliefs, and assumptions) – how its members perceive themselves in relation to the organization's mission and processes. However, when actions are taken in response to perceived gaps, the organization's values, processes, and outcomes may substantially evolve from the current situation. For example, in response to becoming more client-centered, caregivers will broaden their attitudes about client behaviors and their roles in providing care and treatment. This in turn should result in different approaches to working with clients, changes in relationships and power differentials, and in the level and form of caregiver-client interactions.

This change process does not occur immediately and organizations that report success in reshaping their culture and climate indicate that this is a multi-year process. For example, the 99% reduction in the use of restraints reported by Millcreek Behavioral Health Services was attained over a four year period. In the book *Good to Great* (2001), author Jim Collins refers to this as the "fly wheel" principle, as it takes many actions over many years to propel change within the organization. Ultimately, a critical point is reached when these actions start to produce tangible and sustained results. Through use of this instrument for self-assessment, organizations can identify activities that should be initiated to move forward in its goal of reducing seclusion and restraint.

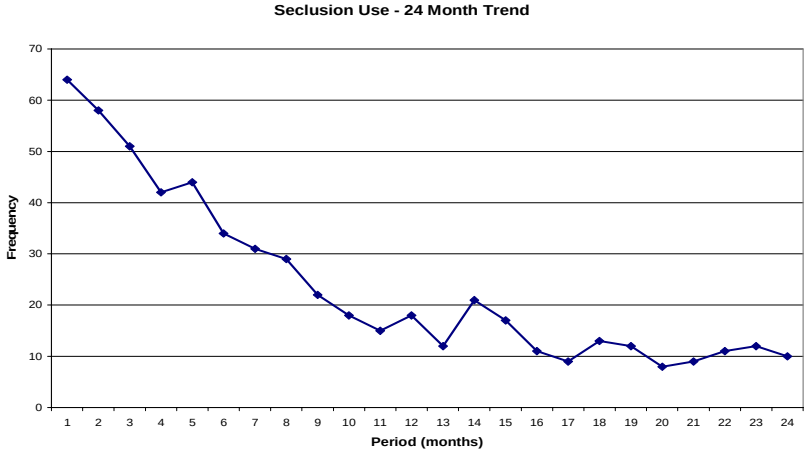
To facilitate the change process, it is helpful to articulate what you believe your organization will look and feel like after it has addressed those factors that are pertinent to your situation; i.e. to conduct "mental imaging" of your organization in response to these changes. For example, someone coming into the organization for the first time might observe the facility director meeting with new employees and expounding with enthusiasm the agency's mission, values, and philosophy of care. On a unit/ward, the visitor would observe verbal interactions that are essentially free of external control language, such as statements starting with the phrase "You need to…" The visitor would find that staff report feeling safer and more confident in their abilities and patients report greater satisfaction in their inpatient experience and the outcomes of treatment.

Finally, continuous evaluation and improvement of processes should produce reductions in seclusion and restraint use (frequency and duration) that are *sustained* over time. Data monitoring and analysis can include the use of graphs to chart the organization's progress. For example, the following graphs illustrate the type of change that should occur as the organizational culture in regard to the use of seclusion and restraint evolves.

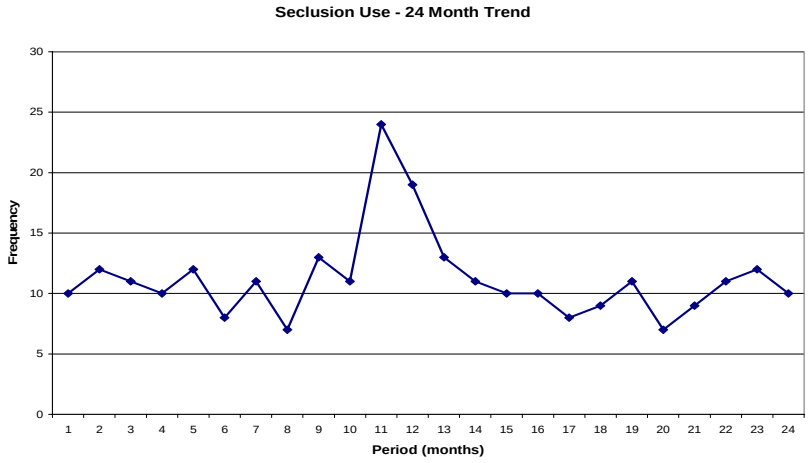
Each graph represents a 24 month period, which should be sufficient to indicate a sustained trend. The first graph depicts an organization that has not implemented or has implemented only a few of the actions outlined in the checklist. In quality improvement parlance, processes are out of control in this facility as there is considerable variation from month to month. This pattern is typically observed when seclusion is applied to a significant percentage of clients served (common cause variation) and/or when the data is skewed by a few clients requiring high utilization of these interventions (special cause variation). When viewed over the short term (for example, between the 7th and 11th months), drops in use may create a false impression that usage is declining and treatment staff may be lolled into believing that their efforts to reduce seclusion and restraint use are working.



The second graph depicts an organization which has been implementing a number of actions to reduce seclusion use. As additional activities are initiated, the use of seclusion decreases. In addition to a downward trend in utilization, there is less variation from month-to-month. Similar trends might be observed when the duration of restrictive interventions are charted, for example, the average amount of time that clients are secluded or restrained should decrease as well as the frequency of these events.



The third graph illustrates an organization that has sustained reductions in seclusion use. However, a recently admitted client has resulted increased use of seclusion and a sudden peak in the data. As alternative treatment approaches are tried, the need for seclusion decreases. Such increases should be anticipated, however when the process is in control [i.e., when treatment teams are able to quickly respond by reassessing the client and modifying the treatment plan (item 6-J)] it should take less time to regain baseline levels of performance.



SUMMARY

The *Checklist for Assessing Your Organization's Readiness for Reducing Seclusion and Restraint* was developed from a comprehensive literature review. The conceptual framework is based on nine themes that reoccurred in the literature and each theme is operationalized by a number of items. The response alternatives have been adapted from the *Transtheoretical Model of Change* as a measure of organizational responsiveness.

The checklist provides a systematic approach for identifying factors that influence the reduction of seclusion and restraint and for assessing the level of progress the organization is making toward implementing/addressing each of these factors. Organizations are encouraged to use this process as a mechanism for change and for supporting an evolution of the organization's values, mission, and practices.

Appendix – Table 1: Comparison of Themes

Instrument (Colton)	CWLA	NTAC	APA, APNA, NAPHS	Delaney	JCAHO (2002)
Leadership	Leadership, Organizational Culture	Leadership toward Organizational Change	Leadership and Culture	Organizational Culture and Leadership	Leadership
Training/Staff Skills	Staff Training and Professional Development	Workforce Development	Staff Education	Building staff skills	Staff Orientation, Training, and Competence Assessment
Staffing				Staff – Creating a pool of expert nurses	Staffing Levels and Scheduling
Physical Environment					
Programmatic Structure	Treatment Milieu		Milieu Management and Early Intervention		Alternatives to Restraint and Seclusion
Responsive and Timely Treatment Planning	Agency Policies, Procedures, and Practices including comprehensive assessment and treatment planning	Use of S/R Reduction Tools	Assessment, Treatment Planning, and Documentation	Client Factors; Unit-Based Consultation	Assessment Clinical Protocols
Processing After the Event/Debriefing	Agency Policies, Procedures, and Practices including monitoring and debriefing	Debriefing Activities	Debriefing	Transactions – Systematic review of restraint events; case reviews	Debriefing
Communication & Consumer Involvement		Consumer Roles in Inpatient Settings		Client Factors; Parent/Child Perceptions	Individual and Family Involvement and Education
Systems evaluation and quality improvement	Continuous Quality Improvement	Use of Data	S&R as a Corporate Performance Improvement Process	Transactions – Case reviews with emphasis on examining the decision-making process	Performance Improvement Activities

Appendix: Training Curriculum

During pretesting of the checklist, several reviewers indicated that it would be helpful to provide information about training curriculum that supports the reduction of seclusion and restraint. There is clearly a consensus in the literature that staff training is one of the most important factors that can influence the reduction of seclusion and restraint. However, as Mohr and Anderson point out, "There is little research suggesting that psychiatric/ mental healthcare staff members have adequate training or skills. . . . The literature also has not documented whether staff members possess the necessary therapeutic skills to respond verbally to patients who are in imminently aggressive states. Rather, it implies that they may not have those skills and that they may precipitate aggressive behavior." (2001, p. 3)

A review of training program descriptions and marketing materials suggests that there is no one, systematic approach currently in use. Additionally, evaluation of the effectiveness of training programs has been generally limited to self-study or is now just being conducted, such as an evaluation of training models being coordinated by the Child Welfare League of American and funded by a SAMHSA grant (Clay, 2004). Nonetheless, as with the development of the checklist, analysis of information related to staff training suggests some reoccurring themes.

Staff training is comprehensive. Those programs that appear to be the most effective tend to cover a broad range of topics, rather than focusing primarily on behavioral interventions such as the proper technique for implementing a physical hold. The training curriculum for Therapeutic Crisis Intervention (Family Life Development Center, 2003) directs users that the training program "should be 4 to 5 days in length with a minimum of 24 hours – if the training is less than 24 hours, physical restraint techniques should not be taught" (p.17). Another example comes from a children's psychiatric hospital where direct care staff were trained in the Boys Town Psychoeducational Treatment Model, which consisted of 40 hours of classroom instruction, over a three week period. Pre and post test ratings of client satisfaction with direct care staff indicated statistically significant differences on the dimensions of fairness, effectiveness, and pleasantness, and improved satisfaction with concern and consistency (Furst, et. al., 1993).

The process for delivering training is resolved. Due to staff shortages, demands placed on staff to provide supervision of violent or self-injurious clients, and resistance to training, organizations often find that it is difficult to ensure that employees receive the amount and level of training desired. Effective organizations recognize the importance of training and therefore address and resolve this problem. For example, when care is competency based, employees are not allowed to work with clients until they have demonstrated a specified level of skill, often measured by a paper and pencil test and/or demonstration of skills. Some organizations require employees to attend training and pass the necessary tests prior to being paid. Many organizations create ingenious scheduling patterns for both trainees and trainers to ensure that training occurs. Finally, when resources permit, additional staff have been hired to support the training process (Campbell, 2003).

Training makes use of a variety of teaching approaches. An effective training curriculum is not limited to classroom lectures and presentations. A variety of approaches are used including role playing, live demonstrations, and practice sessions (Furst, ibid.). This is often coupled with mentoring and coaching during the employees first weeks and months on the job. Training is often competency based to ensure that the employee demonstrates expected skills and abilities *before* interacting with clients.

The curriculum provides conceptual information. An effective training program will include lessons that cover human growth and development, the needs and behaviors of the population(s) served, use of medications (including risks versus benefits), and principles of behavior including learning theory and behavior modification. Specific examples are used to demonstrate how these concepts apply to the clients the employee will work with and how this information can be used to assess and work with individuals (for example, how this information is incorporated into development of the client's treatment plan).

The curriculum orients the employee to the organization's policies, procedures, and programs. The organization's values, goals, and strategies regarding effective treatment, including use of seclusion and restraint, are explained and discussed. Employees should be encouraged to reflect on their own values and beliefs and how they compare and contrast to the organization's values. Training therefore becomes part of the organization's culturalization process. Specific policies and procedures regarding the use of seclusion and restraint should be introduced and included as part of the more detailed process of implementing these interventions.

Training focuses on building effective interpersonal skills, which provides staff with a repertoire of interventions that can be used prior to implementing more restrictive interventions. This part of the curriculum concentrates on such areas as: situation assessment, building relationships, avoiding power struggles, providing direction and support in positive manner, active listening, mediation, and personal stress management. Some programs also provide staff with the fundamentals of social skills training, so that they can reinforce those skills during their interactions with clients.

The curriculum includes a "module" that specifically focuses on the use of restraint and seclusion. This aspect of training addresses all activities associated with a crisis situation which might result in the use of seclusion and/or restraint and typically includes:

- Policies and procedures relating to the use, documentation, and monitoring of S/R.
- Liability and risks.
- The underlying causes of threatening behaviors exhibited by clients (the anger and crisis cycles).
- Physical, cognitive, social, and emotional precipitants of behavior.
- Recognizing how demographic factors (age, gender, ethnicity, history of abuse) influence how clients experience S/R (trauma informed care).
- Assessing the situation.
- How staff interactions can affect the behaviors of the client.
- Awareness of self during the interaction, including transference, and countertransference.
- De-escalation strategies.
- Addressing staff and client safety including recognizing and addressing signs of physical, cognitive, and emotional distress (physiological and psychological affects).
- Proper and allowable techniques for implementing seclusion, physical holds and/or mechanical restraints.
- Indicators for discontinuing S/R.
- Debriefing and processing with the client after the event. (Staff are taught how to conduct a debriefing and how to use the information that comes out of that process to improve practice.)
- Re-engaging the client and assisting reentry to the treatment milieu.
- Team debriefing.
- Documentation requirements.

(JCAHO, 2002; Family Life Development Center, 2003; Bullard, et. al., 2003; and Pennsylvania Dept. of Public Welfare, 2003)

Appendix – Table 2: Guidelines for Program Development

The Program Should (Be):	**Because:**
Involve all potential stakeholders in the design and development of the program.	Research indicates that programs are more likely to be implemented as intended if stakeholders are involved in its development. Stakeholders would include treatment staff, clients and their families.
Simple to implement by staff.	Enhances consistent and stable application of the program. Enhances the time it takes for new employees to learn the program.
Simple for the clients to understand (i.e., does not involve complex procedures).	Helps new clients learn the program quickly. Reduces opportunities for conflicts/power struggles over rules and expectations.
Stated clearly, succinctly, and is written at a reading level the majority of clients can comprehend.	Enhances the client's ability to make use of the program. Reduces ambiguity, which in turn reduces conflicts over the meaning of the program.
Based on a values system.	Values create a foundation for the program. The underlying values, such as empowerment, acceptance of responsibility, and social appropriateness should be articulated to clients, their families, and staff.
Based on evidence-based practice.	The program should be based on available literature of what works and why. To the extent possible, research should indicate effective practices and "best practice" models.
Based on an understanding that change and development is not a linear process.	People learn from their experiences, both successful and unsuccessful. People learn at their own pace and in their own style.
Based on the assumption that the most effective change (cognitively, affectively, and behaviorally) comes from within (taking into account an individual's level of development).	A therapeutic program attempts to provide a context for interactions and personal development for all clients. External approaches for influencing behaviors may not be appropriate for all members of the therapeutic community based on their stage of personal development.
Based on expectations that are reasonable and which enhance the goals and values of the program.	A few rules that clients can readily comply with are better then many rules that cannot be enforced and which may encourage clients to attempt to circumvent them.
Structured so that each day proceeds in a logical, orderly and systematic fashion. Rituals and routines are used to support underlying expectations.	Structure helps clients who have difficulty exerting internal control. In general, people dislike ambiguity and uncertainty and do best when expectations are clear. (However, there must a balance between a highly structured environment and one that enhances opportunities for choice. This should take into consideration the client's developmental readiness.)
Empower clients to make effective choices that do not harm others (mentally, emotionally, or physically): a core value.	The program is based on enhancing internal/self-control and decreasing the need for external controls to behaviors.
Makes use of natural consequences, which are used to enhance the process of "learning by experience".	Consequences make sense in the context of the milieu, social interactions, and the client's stage of development.

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Checklist for Assessing Your Organization's Readiness for Reducing Seclusion and Restraint

Purpose: To provide behavioral healthcare organizations with a systematic approach for identifying factors that influence the reduction of seclusion and restraint and for assessing the level of progress the organization is making toward implementing and addressing each of these factors.

Instructions:

- This instrument should be used to complete an organizational wide assessment of the efforts to reduce the use of restrictive interventions. The process will typically involve facility administrators, program managers, clinicians, trainers/educators, and other service providers including nurses and behavioral technicians.

- In addition to an organizational assessment, sections of this instrument may be completed by a specific work unit or committee. For example, the section on training might be completed by the facility training committee and the section on programmatic structure might be completed by the staff on a unit or ward.

- Place a check in the box that best corresponds to your agency's current level of progress. Use this information to determine which areas need the most attention.

- To ensure a comprehensive assessment the checklist should be completed by more than one individual. They should then discuss their ratings and through a process of consensus building, reach a level of agreement regarding the rating which reflects the progress your organization is making on each of the factors.

- The checklist should be completed at regular intervals to assess ongoing progress.

1. Leadership:

0 = Insufficient Information and/or additional information needed to make this assessment	**1 = No Action / No Discussion** (Little if any recognition that there is a problem)	**2 = Espoused** (Some discussion and possibly some planning, but still no action)	**3 = Intermittent/ Inconsistent Action** (Some steps taken, but not necessarily as part of a well thought out strategy)	**4 = Action** (Activities are consistent and based on strategic plans)	**5 = Sustained Action** (Strategically focused activities are maintained over time)

A. Through his/her actions, the CEO (administrator/director) demonstrates commitment to the goal and process of reducing seclusion and restraint.	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
B. Management has articulated (verbally and in writing) a vision regarding the facility's safe and appropriate use of seclusion and restraint.	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
C. Management has articulated (verbally and in writing) that it values a "learning environment" where non-punitive approaches are used to correct and improve employee performance. (With the exception of violations of patient abuse policy.)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
D. Management has articulated (verbally and in writing) its intention of reducing the use of seclusion and restraint and/or to eliminate their use entirely.	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
E. A strategic plan has been developed outlining the goals and actions that will be taken to reduce the use of seclusion and restraint.	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
F. The organization's goals and plans to reduce seclusion and restraint are documented and articulated to staff through a number of mechanisms such as newsletters, memos, staff meetings, and through the orientation and training process.	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
G. Clinical leadership has articulated a philosophy of treatment based on emphasizing positive behavior and de-emphasizing the use of restrictive interventions as an approach to behavior support and intervention.	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
H. The organization's policy and procedure on the use of seclusion and restraint has been revised to reflect the organization's vision, mission, and philosophy of treatment.	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
I. Policies ensure that physicians and nurses are involved in the process of initiating seclusion and restraint.	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
J. The infrastructure and resources (such as committees, data sources, crisis intervention teams, etc.) needed to implement the plan to reduce seclusion and restraint has been put into place.	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
K. Staff at all levels of the organization are encouraged and invited to participate in the change process.	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
L. A mechanism has been created (typically a committee or individual) to ensure that all seclusions and restraints are reviewed for appropriate implementation.	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
M. A mechanism has been created (e.g., a committee or individual) that ensures the organization is making progress in achieving its goals and strategic plan to reduce use of these interventions.	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5

2. Orientation and Training of Caregiver Staff:

1 = No Action / No Discussion (Little if any recognition that there is a problem)	**2 = Espoused** (Some discussion and possibly some planning, but still no action)	**3 = Intermittent/ Inconsistent Action** (Some steps taken, but not necessarily as part of a well thought out strategy)	**4 = Action** (Activities are consistent and based on strategic plans)	**5 = Sustained Action** (Strategically focused activities are maintained over time)	**0 = Insufficient Information** and/or additional information needed to make this assessment

A. There is a comprehensive training curriculum that addresses behavior support and intervention.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
B. Attendance at initial and refresher courses is mandatory for all treatment staff.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
C. The training program combines classroom instruction with coaching and supervision to ensure that transfer of learning occurs.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
D. Varied training modalities are used, including the use of lectures, videos, live demonstrations, and role-playing.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
E. Training is used to orient new employees to the organization's philosophy of treatment.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
F. The organization's policies and procedures on the use of seclusion and restraint are presented during training.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
G. As appropriate, training is competency based (employees demonstrate the expected level of competency before being allowed to implement an intervention/work with clients).	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
H. Training provides a repertoire of approaches that can be used to de-escalate clients.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I. Training sensitizes staff to client needs.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
J. Training sensitizes staff as to how clients experience the restrictive interventions (for example, training explains how a client's history can influence their experience and reaction to seclusion and restraint).	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
K. Training describes the concept of countertransference and how it may influence the manner in which staff implements the intervention.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
L. Training sensitizes staff to the power differential that exists when seclusion and restraint are applied.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
M. Staff are taught how to recognize and respect interpersonal boundaries.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
N. All employees with client contact receive the same training, including part-time and contractual employees.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
O. Retraining and refresher courses to keep staff current in their knowledge, skills, and abilities are regularly scheduled and delivered consistently.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
P. Training is supported through mentoring, coaching, and supervision.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

3. Staffing:

1 = No Action / No Discussion (Little if any recognition that there is a problem)	2 = Espoused (Some discussion and possibly some planning, but still no action)	3 = Intermittent/ Inconsistent Action (Some steps taken, but not necessarily as part of a well thought out strategy)	4 = Action (Activities are consistent and based on strategic plans)	5 = Sustained Action (Strategically focused activities are maintained over time)	0 = Insufficient Information and/or additional information needed to make this assessment

	0	1	2	3	4	5
A. Staffing patterns are assessed to ensure that adequate numbers of employees are available at critical times, such as during transitions, at change of shift, in the evening, and at times of high acuity.	☐	☐	☐	☐	☐	☐
B. Scheduling ensures that staff have time for needed training.	☐	☐	☐	☐	☐	☐
C. Work schedules and staffing levels support opportunities for relief time to reduce burnout.	☐	☐	☐	☐	☐	☐
D. Consideration is given to the mix of employees who implement interventions (e.g., age, gender, academic preparation, experience, and ability to relate to the client).	☐	☐	☐	☐	☐	☐
E. The organization has developed a process that ensures staff are assigned where and when needed across shifts and units/wards, such as an agency-wide master schedule.	☐	☐	☐	☐	☐	☐
F. To enhance staff empowerment, direct care and nursing employees are provided opportunities for self-scheduling and alternative schedules (such as flex-time).	☐	☐	☐	☐	☐	☐

4. Environmental Factors:

1 = No Action / No Discussion (Little if any recognition that there is a problem)	2 = Espoused (Some discussion and possibly some planning, but still no action)	3 = Intermittent/ Inconsistent Action (Some steps taken, but not necessarily as part of a well thought out strategy)	4 = Action (Activities are consistent and based on strategic plans)	5 = Sustained Action (Strategically focused activities are maintained over time)	0 = Insufficient Information and/or additional information needed to make this assessment

	0	1	2	3	4	5
A. The environment is consistently and systematically evaluated for safety hazards. For example, furniture is selected that cannot be easily thrown.	☐	☐	☐	☐	☐	☐
B. To ensure client safety, steps are taken to reduce blind corners in seclusion rooms, such as through the use of security cameras.	☐	☐	☐	☐	☐	☐
C. Seclusion rooms are renovated to reduce isolation and increase visual stimulation. For example, rooms are painted warm colors or where regulations permit, have windows with views to the outdoors.	☐	☐	☐	☐	☐	☐
D. As appropriate, sound reducing materials, such as carpeting and special ceiling tiles, are used to reduce noise in patient living areas.	☐	☐	☐	☐	☐	☐
E. To reduce the association between seclusion and time out, as resources permit, separate rooms are designated for time out/calming rooms.	☐	☐	☐	☐	☐	☐

5. Programmatic Structure:

1 = No Action / No Discussion (Little if any recognition that there is a problem)	**2 = Espoused** (Some discussion and possibly some planning, but still no action)	**3 = Intermittent/ Inconsistent Action** (Some steps taken, but not necessarily as part of a well thought out strategy)	**4 = Action** (Activities are consistent and based on strategic plans)	**5 = Sustained Action** (Strategically focused activities are maintained over time)	**0 = Insufficient Information** and/or additional information needed to make this assessment

A. To provide structure for clients and staff, there is a written program description that clearly outlines expectations, routines, and rules.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
B. The program and/or program components are grounded in theory and to the extent possible are evidence-based.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
C. The programmatic structure, such as rules, routines, and expectations, is designed to empower clients to make effective choices that do not harm themselves or others (mentally, emotionally, or physically).	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
D. Program rules and expectations are based on enhancing internal/self-control and decreasing the need for external controls to behaviors.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
E. The program makes use of natural consequences, which are used to enhance the process of "learning by experience". (For example, consequences make sense in the context of the milieu, social interactions, and the client's stage of development.)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
F. The program is designed to reduce downtime by engaging clients in constructive activities, related to treatment goals.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
G. The program also provides ample time for rest, relaxation, recreation, and activities of daily living.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
H. Level systems and token economies are based on the needs of the population served, rather than as a standard approach to providing programmatic structure.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I. When used, level systems and token economies are developmentally appropriate and focused on the use of positive reinforcement as the primary motivation to change.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
J. Transitions are scheduled and structured to reduce difficulties clients may have coping with changes in their routines.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
K. Rules and expectations are reasonable and fair, so that clients can readily comply with them rather than attempting to circumvent them or engaging in power struggles over them.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
L. Unit/ward rules are explained during the orientation period and an effort is made to obtain agreement from the client to abide by these expectations.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
M. The program provides for the normalization of routine activities, such as telephone privacy, access to snacks, etc.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
N. The program is designed to empower clients and thereby reduce conflict (such as making it easier for clients to have access to the telephone or their own money during the day).	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
O. Staff receive training and supervision to ensure that the program is delivered as intended on a consistent basis.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

6. Timely and Responsive Assessment and Treatment Planning:

1 = No Action / No Discussion (Little if any recognition that there is a problem)	**2 = Espoused** (Some discussion and possibly some planning, but still no action)	**3 = Intermittent/ Inconsistent Action** (Some steps taken, but not necessarily as part of a well thought out strategy)	**4 = Action** (Activities are consistent and based on strategic plans)	**5 = Sustained Action** (Strategically focused activities are maintained over time)	**0 = Insufficient Information** and/or additional information needed to make this assessment

A. Assessment is case specific and client centered.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
B. Assessment includes information describing the antecedents to aggression and/or self-harmful behaviors.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
C. Assessment identifies approaches that have been tried, worked or failed in managing aggression and/or self-harmful behaviors.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
D. Assessment and treatment planning identify strengths and deficits in coping skills.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
E. Assessment identifies preferred treatment interventions.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
F. Treatment plans prescribe individualized behavioral interventions, so that staff are not constantly reacting to a specific client's aggression/self-harm.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
G. Treatment planning involves the client and family to the fullest extent possible. (Every effort is made to engage the client and family, so that they do not perceive it as just a process where others do something to/for them.)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
H. Assessment and treatment planning is timely and responsive.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I. Caregiver staff (i.e., aides/technicians), are involved in treatment decisions, such as decisions about passes, transfers, and readiness for discharge.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
J. Treatment plans are revised to meet a client's ongoing needs, response to treatment efforts, and use of seclusion and restraint.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
K. The organization identifies thresholds that are used to signal the need for external review of the client's treatment plan, particularly when there is high use of seclusion or restraint.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
L. The organization has a behavioral management/clinical review committee to provide consultation in the development of treatment plans to manage aggression.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

7. Processing After the Event (debriefing):

1 = No Action / No Discussion (Little if any recognition that there is a problem)	2 = Espoused (Some discussion and possibly some planning, but still no action)	3 = Intermittent/ Inconsistent Action (Some steps taken, but not necessarily as part of a well thought out strategy)	4 = Action (Activities are consistent and based on strategic plans)	5 = Sustained Action (Strategically focused activities are maintained over time)	0 = Insufficient Information and/or additional information needed to make this assessment

A. The process for conducting client – staff debriefings (i.e., meeting with the client to process the event) is outlined in a written policy.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
B. The process for debriefing clients is a component of the organization's training curriculum.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
C. Client –staff debriefings take into consideration the client's level of functioning. For example, staff recognize that a client may lack the analytical and verbal skills needed to assess their own behaviors.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
D. Client – staff debriefings attempt to explain why the intervention was necessary, with the opportunity for the client to respond when appropriate and safe.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
E. The client – staff debriefing is used to identify triggers and antecedents to behaviors that led to the need for staff to intervene and assist.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
F. The client – staff debriefing is used to identify alternative de-escalation strategies that can be made a part of the client's treatment plan.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
G. The timing of the client debriefing is considered. (The client may not be calm enough to reflect on his/her behaviors and alternatives immediately after the intervention. Conversely, there may be too much of a 'disconnect' if the timing of the debriefing is prolonged.)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
H. The client – staff debriefing is used as a time to reconnect with staff.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
I. Staff-to-staff debriefings address issues related to countertransference.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
J. Opportunities are provided/scheduled to process the event with staff about their feelings, reactions, and safety.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
K. The organization considers the use of staff support groups, counseling, or other systematic approaches to help staff work through their feelings.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
L. Staff-to-staff debriefings focus on what worked, didn't work, and different approaches that might be tried in the future.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
M. Staff are involved in assessing and monitoring to ensure interventions are implemented correctly and that the restrictive intervention accomplished the purpose for which it was intended.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
N. The facility has a mechanism for collecting information about and analyzing the results of debriefings to improve organizational performance, such as revising policies and procedures, adjusting training, and adjusting schedules.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	

8. Communication and Consumer Involvement:

1 = No Action / No Discussion (Little if any recognition that there is a problem)	**2 = Espoused** (Some discussion and possibly some planning, but still no action)	**3 = Intermittent/ Inconsistent Action** (Some steps taken, but not necessarily as part of a well thought out strategy)	**4 = Action** (Activities are consistent and based on strategic plans)	**5 = Sustained Action** (Strategically focused activities are maintained over time)	**0 = Insufficient Information** and/or additional information needed to make this assessment

A. Clients are not isolated from contact during the intervention – staff interact with the client during the seclusion or restraint.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
B. Staff are responsive to the client's needs to interact and reintegrate back into the milieu after the intervention.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
C. Families are informed of the organization's S/R policies and are informed when these interventions are used, including an explanation as to why the intervention was necessary.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
D. Communications with clients and their families is respectful of their needs and situations.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
E. The organization's treatment philosophy emphasizes a consumer orientation such as including patients and families in the treatment planning process.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
F. Upon admission, clients and their families are oriented to the unit and program, including the use of seclusion and restraint.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
G. Clients and their families are involved in treatment and discharge planning.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
H. There is a process in place to inform family members of significant changes in the client's condition and/or response to treatment.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I. The organization makes use of client and family satisfaction surveys to inform decision making.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
H. Management provides opportunities for consumers and/or consumer groups to have input and/or provide feedback into the development and review of programs, processes, policies, and procedures.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I. Management ensures that the client advocacy/ombudsman program is involved in the development and review of programs and processes that support the empowerment of clients and the reduction of restrictive interventions.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

9. Systems Evaluation and Quality Improvement:

1 = No Action / No Discussion (Little if any recognition that there is a problem)	**2 = Espoused** (Some discussion and possibly some planning, but still no action)	**3 = Intermittent/ Inconsistent Action** (Some steps taken, but not necessarily as part of a well thought out strategy)	**4 = Action** (Activities are consistent and based on strategic plans)	**5 = Sustained Action** (Strategically focused activities are maintained over time)	**0 = Insufficient Information** and/or additional information needed to make this assessment

A. The organization has established policies, procedures, and systems for continuous evaluation of the need for and appropriate use of seclusion and restraint.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
B. There is a systematic data management process in place relevant to seclusion and restraint use.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
C. The data management process ensures for the accuracy of seclusion and restraint data.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
D. Data is made available to treatment teams so that they can measure the effects of their efforts to reduce the use of seclusion and restraint.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
E. Data about the frequency and duration of restrictive interventions is made available for review and analysis on a daily basis.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
F. Data provides information about both long-term (months/years) and short-term (weeks/months) utilization of seclusion and restraint.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
G. Data is used to examine the relationship between the use of seclusion and restraint and other factors, such as patient injuries; staff injuries; use of medications; patient and staff demographics; and the like.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
H. There is an internal audit system to investigate incidents and provide information that can be used to correct problems and improve the quality of care.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I. The organization makes use of quality improvement tools, such as cause and effect analysis, Pareto analysis, scattergrams, statistical process control, and the 'repetitive why' approach to analyze the data.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
J. Qualitative data is reviewed, including incident reports and seclusion and restraint documentation, to assess opportunities for improvement.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
K. Client satisfaction questionnaires include items that collect data about the client's experience in the use of seclusion and/or restraint.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
L. Data is used to measure the extent that seclusion and restraint reduction goals and plans are being achieved.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
M. There is written evidence of action taken to reduce the use of seclusion and restraint in response to data analysis, such as meeting minutes and/or quality improvement documents.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5